William D. Bateman, DMD
FAMILY, RESTORATIVE, & IMPLANT DENTISTRY

William D. Bateman, DMD
1995 Commercial St. SE #200
Salem, OR 97302
Tel: (503) 375-0007
Fax: (503) 588-7454

CONFIDENTIAL INFORMATION QUESTIONNAIRE

Please Print, Fill-Out and Bring into Your First Visit

PATIENT'S NAME LAST FIRST MIDDLE	DATE OF BIRTH	SEX	SOCIAL SECURITY #
PATIENT'S ADDRESS STREET APT# CITY STATE ZIP			HOME PHONE
MARITAL STATUS ☐ M ☐ S ☐ D ☐ W ☐ UNDER AGE 18	PATIENT'S/ GUARDIAN'S EMPLOYER		OCCUPATION
WORK ADDRESS STREET CITY STATE ZIP	WORK PHONE		OK TO CALL WORK? ☐ YES ☐ NO
PERSON WE CAN CONTACT IN CASE OF AN EMERGENCY (OTHER THAN YOUR FAMILY HOME) NAME RELATIONSHIP WORK # HOME #			
OTHER FAMILY MEMBERS THAT ARE PATIENTS HERE	WHO WE CAN THANK FOR REFERRING YOU TO OUR OFFICE		

INSURANCE AND FINANCIAL INFORMATION

INSURANCE COVERAGE ☐ YES ☐ NO	INSURANCE COMPANY NAME INSURANCE PHONE INSURANCE ADDRESS		
SUBSCRIBER'S NAME	PATIENT RELATIONSHIP TO SUBSCRIBER ☐ PATIENT ☐ SPOUSE ☐ DEPENDENT	SUBSCRIBER'S DATE OF BIRTH	EMPLOYER ADDRESS
GROUP/PROGRAM NUMBER	EMPLOYER (IF DIFFERENT THAN ABOVE)		EMPLOYER ADDRESS
SECONDARY COVERAGE ☐ YES ☐ NO	INSURANCE COMPANY NAME INSURANCE PHONE INSURANCE ADDRESS		
SUBSCRIBER'S NAME	PATIENT'S RELATIONSHIP TO SUBSCRIBER ☐ SELF ☐ SPOUSE ☐ DEPENDENT	SUBSCRIBER'S DATE OF BIRTH	SUBSCRIBER'S SSN
GROUP/PROGRAM NUMBER	EMPLOYER (IF DIFFERENT THAN ABOVE)		EMPLOYER ADDRESS

ASSIGNMENT & RELEASE

I hereby authorize my insurance benefits to be paid directly to the dentists. I am financially responsible for any balances due and authorize the dentists to release any information for this claim. I authorize that my records can be used by the doctor if he so determines.
In consideration of the services rendered to me by this dental office I am obligated to pay said office in accordance with its credit terms and policies.
I consent to the making of videotapes, photographs, and x-rays before, during, and after treatment, and to the use of same by the doctor in scientific papers or demonstrations.
I certify that I have read or had read to me the contents of this form and do realize the risks and limitations involved.

Signature: ____ Date: ______________________